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ALDERSGATE VILLAGE	3220 SW ALBRIGHT DR TOPEKA, KS 66614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS58911 done under the Quality Indicator Survey process.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: The facility identified a census of 171 residents. The sample included 29 residents. Based on observation, record review, and staff interview, the facility failed to develop a comprehensive care plan for 1(#194) resident of the 3 residents sampled for restorative.	F 279		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 279	Continued From page 1 Findings included: - The admission minimum data set (MDS) dated 5/11/12 for resident #194 revealed the resident had severely impaired cognitive skills for decision making; the resident required extensive assist with two plus persons physical assist with bed mobility, transfers, dressing, toilet use, and personal hygiene; extensive assist of one person physical assist with locomotion on the unit and eating; total dependence of one person physical assist with locomotion off the unit; the resident did not have limitation in range of motion (ROM) to the upper or lower extremities; a wheelchair was used for mobility; and the resident received 303 minutes of occupational therapy (OT) and 269 minutes of physical therapy (PT) in the last seven day. The OT discharge note dated 5/22/12 revealed the OT staff recommended a restorative aide program for passive ROM (PROM), feeding, and grooming. The 5/24/12 restorative care program form revealed the goals for bilateral upper extremity ROM were to maintain hands for feeding and grooming. The PT discharge note dated 6/4/12 revealed PT recommended a restorative program to maintain ROM of the bilateral lower extremities; and used a lower extremity positioning device to prevent further contracture of the lower extremity. The care plan dated 5/14/12 for activities of daily living (ADLs) revealed the resident used a Broda	F 279		

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F 279	Continued From page 2	F 279		

chair and was unable to propel his/her own self; staff provided extensive to total assist for all activities of daily living (ADLs), repositioning, and transfers; and staff used lower extremity positioning device when the resident was supine.

The care plan lacked interventions for the restorative program.

The restorative nursing assessment dated 7/20/12 revealed the resident had right and left hip/knee contracture; the resident had functional limitation in the ROM to the leg which included the hip and knee, and indicated limitation and full loss of both sides; the resident had minimal loss of dorsiflexion of both ankles and extension of both hips; and moderate to severe partial loss of extension of both knees.

Observation on 8/2/12 at 12:59 P.M. revealed the resident sat in the dining room in a Broda chair wearing foam boots on each foot.

Observation on 8/6/12 at 4:30 P.M. revealed the resident laid in bed sleeping.

Staff interview on 8/7/12 at 3:05 P.M. with administrative nursing staff D revealed all disciplines are responsible for updating the care plans. The restorative care plan was created when physical and occupational therapy recommendations were made.

The undated policy and procedure for comprehensive care plans revealed the resident's comprehensive care plan was designed to identify the professional services that were responsible for each element of care; aid in

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F 279	Continued From page 3 preventing or reducing declines in the resident' functional status and/or functional levels; enhance the optimal functioning of the resident by focusing on a rehabilitative program; and reflect currently recognized standards of practice for problem areas and conditions. The facility failed to develop a comprehensive care plan regarding restorative services for this resident with decreased range of motion.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: The facility identified a census of 171 residents.	F 280		

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The sample included 29 residents. Based on observation, interview, and record review the facility failed to individualize the care plan to reflect the resident's preferences for oral care, shaving, and catheter bag placement for 1 of 29 residents reviewed. (#1)

Findings included:

- Resident #1's annual Minimum Data Set 3.0 Assessment (MDS) dated 7-4-12 documented the resident with moderately impaired decision making skills. The resident required total assistance of staff for personal hygiene and bathing. The resident had an indwelling foley catheter and was incontinent of bowel.

The Cognition Care Area Assessment summary (CAA) dated 7-24-12 documented the resident refused care during the observation period, was alert and oriented to person, place and time, able to make decisions about his/her daily care, and able to communicate his/her needs.

The Activities of Daily Living (ADLs) CAA dated 7-24-12 documented the resident was aphasic (total inability to produce and understand speech as a result of brain damage caused by injury or disease), and had a neurogenic (dysfunction of the urinary bladder/bowels due to disease of the central or peripheral nervous system involved in the control of urination and/or bowel movements) bowel and bladder. The CAA documented the resident required extensive to total assistance from staff for all daily ADLs except feeding, which he/she continued to be able to do on his/her own most of the time. The resident became agitated, combative, and resistive with staff at times during

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F 280	Continued From page 5	F 280		

his/her cares and staff re-approached after a short period of time to continue with cares. The resident received physical, speech, and occupational therapies following a motor vehicle crash (MVC) and had contractures and decreased mobility of his/her upper and lower extremities.

The Dental CAA dated 7-24-12 documented the resident with a number of his/her own natural teeth missing, and remaining teeth broken off or with fillings and required extensive to total assistance from staff for completion of his/her daily oral hygiene needs.

The Behavioral CAA dated 7-24-12 documented the resident with behavioral symptoms that varied from day to day and shift to shift and he/she had less behavioral outbursts with a consistent routine with consistent care givers. When he/she had periods of agitation and/or behavioral symptoms, staff allowed the resident time to de-escalate and returned a short time later to resume his/her cares. The staff used a dry erase board to communicate with the resident.

The Incontinence /indwelling catheter CAA dated 7-24-12 documented the resident was quadriplegic (paralysis of both arms and legs), aphasic, had traumatic brain injury with organic brain syndrome, and a neurogenic bladder and bowel. The resident had a suprapubic catheter and staff monitored the output.

The 7-24-12 revised care plan identified the resident with a deficit in self care related to his/her impaired mobility and required total care for most ADLs. The interventions directed staff

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to provided catheter care daily every shift, check every 2 hours for bowel movements, monitor for adequate urinary output and place the tubing and collection bag to promote adequate drainage and maintain patency, required assistance with oral care daily, and monitor the resident's supra pubic catheter and place the tubing and bag for adequate drainage.

Observation on 8/1/2012 at 2:29 P.M. revealed the resident in bed alert with catheter tubing attached to a foley catheter bag placed in a privacy bag and hung on the side of the bed. The room smelled strongly of urine. The resident's face had several days growth of facial hair and his/her teeth had food debris.

Observation on 8-6-12 at 11:43 A.M. revealed the resident in bed and the room smelled of strong body odor. The resident had a large amount of facial hair, long fingernails, hair unkempt, and food debris on his/her teeth. Licensed nurse N removed the undated dressing from around the resident's supra pubic catheter insertion site, when finished licensed nurse N acknowledged the resident's facial hair and informed the resident staff would shave the resident with his/her bath tomorrow.

Observation on 8-7-12 at 10:40 A.M. revealed the resident unshaved and longer facial hair growth, food debris on his/her teeth, hair unkempt and oily in appearance and the resident's room smelled of strong body odor. Direct care staff FF and EE explained to the resident they were going to place him/her in the Hoyer lift and take him/her to the shower room. The resident approved and direct care staff FF and EE placed the resident in

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the sling and attached it to the Hoyer lift and began to raise the resident off the bed when the resident hollered for the catheter bag continuously until staff placed the bag in his/her hand. Staff FF stated the resident insisted he/she hang onto the catheter bag with transfers.

During staff interview on 8-6-12 at 3:39 P.M. direct care staff GG stated he/she shaved residents when he/she noticed facial hair on residents.

During staff interview on 8-7-12 at 9:46 A.M. direct care staff FF stated the resident was not able to do anything for him/herself except eat after staff provided set-up. He/she stated the resident did not get out of bed except for bath days and would receive a bath today. He/she stated staff shaved and brushed the resident's teeth on bath days only because he/she refused care often especially with staff he/she did not know.

During staff interview on 8-7-12 at 11:14 A.M. licensed nurse N acknowledged the resident and his/her room with the smell of urine and body odor. He/she stated the unit manager updated care plans quarterly.

During staff interview on 8-7-12 at 1:20 P.M. administrative nurse F acknowledged the resident had body and urine odors and refused care often from staff he/she did not know. He/she acknowledged the care plan lacked individualized interventions specific to the resident's grooming.

The revised care plan dated 7-24-12 failed to include his/her individualized preferences

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F 280	Continued From page 8 regarding shaving, oral care, and handling the foley catheter bag. The facility provided October 2010 Assessments and Care Plans documented the care plans were revised as information about the resident and the resident's condition changed. The facility failed to review and revise this dependent resident's care plan to reflect his/her individual preferences.	F 280		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: The facility identified a census of 171 residents. The sample included 29 residents. Based on observation, interview, and record review the facility failed to provide adequate grooming and oral care for 1 of 3 residents reviewed for activities of daily living (ADLs). (#1) Findings included: - Resident #1's annual Minimum Data Set 3.0 Assessment (MDS) dated 7-4-12 documented the resident with moderately impaired decision making skills. The resident required total assistance of staff for personal hygiene and bathing. The resident had an indwelling foley	F 312		

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F 312	Continued From page 9	F 312		

catheter and was incontinent of bowel.

The Cognition Care Area Assessment summary (CAA) dated 7-24-12 documented the resident refused care during the observation period, was alert and oriented to person, place and time, able to make decisions about his/her daily care, and able to communicate his/her needs.

The Activities of Daily Living (ADLs) CAA dated 7-24-12 documented the resident was aphasic (total inability to produce and understand speech as a result of brain damage caused by injury or disease), and had a neurogenic (dysfunction of the urinary bladder/bowels due to disease of the central or peripheral nervous system involved in the control of urination and/or bowel movements) bowel and bladder. The CAA documented the resident required extensive to total assistance from staff for all daily ADLs except feeding, which he/she continued to be able to do on his/her own most of the time. The resident became agitated, combative, and resistive with staff at times during his/her cares and staff re-approached after a short period of time to continue with cares. The resident received physical, speech, and occupational therapies following a motor vehicle crash (MVC) and had contractures and decreased mobility of his/her upper and lower extremities.

The Dental CAA dated 7-24-12 documented the resident with a number of his/her own natural teeth missing, and remaining teeth broken off or with fillings and required extensive to total assistance from staff for completion of his/her daily oral hygiene needs.

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The Behavioral CAA dated 7-24-12 documented the resident with behavioral symptoms that varied from day to day and shift to shift and he/she had less behavioral outbursts with a consistent routine with consistent care givers. When he/she had periods of agitation and/or behavioral symptoms, staff allowed the resident time to de-escalate and returned a short time later to resume his/her cares. The staff used a dry erase board to communicate with the resident.

The 7-24-12 revised care plan identified the resident with a deficit in self care related to his/her impaired mobility and required total care for most ADLs. The interventions directed staff to provided catheter care daily every shift, check every 2 hours for bowel movements, monitor for adequate urinary output and place the tubing and collection bag to promote adequate drainage and maintain patency, required assistance with oral care daily, and monitor the resident's supra pubic catheter and place the tubing and bag for adequate drainage.

Record review of the Intervention/Task sheet where the certified nursing assistants (CNAs) documented cares for each resident revealed codes used by the CNAs for each care and code 98 depicted if a resident refused care. Record review for bathing and personal hygiene for July and through August 6th, 2012 lacked documentation the resident refused care and received total assistance with personal hygiene and bathing on July 31st, 2012 and on August 1st through the 5th.

Observation on 8/1/2012 at 2:29 P.M. revealed the resident's room smelled strongly of urine.

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The resident's face had several days growth of facial hair and his/her teeth had food debris.

Observation on 8-6-12 at 11:43 A.M. revealed the resident in bed and the room smelled of strong body odor. The resident had a large amount of facial hair, long fingernails, hair unkempt, and food debris on his/her teeth. Licensed nurse N removed the undated dressing from around the resident's supra pubic catheter insertion site, when finished licensed nurse N acknowledged the resident's facial hair and informed the resident staff would shave the resident with his/her bath tomorrow.

Observation on 8-7-12 at 10:40 A.M. revealed the resident unshaved and longer facial hair growth, food debris on his/her teeth, hair unkempt and oily in appearance and the resident's room smelled of strong body odor.

During staff interview on 8-7-12 at 9:46 A.M. direct care staff FF stated the resident was not able to do anything for him/herself except eat after staff provided set-up. He/she stated the resident did not get out of bed except for bath days and would receive a bath today. He/she stated staff shaved and brushed the resident's teeth on bath days only because he/she refused care often especially with staff he/she did not know.

During staff interview on 8-7-12 at 11:14 A.M. licensed nurse N acknowledged the resident and his/her room with the smell of urine and body odor. He/she stated the resident refused care often with staff he/she did not know.

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F 312	Continued From page 12 During staff interview on 8-7-12 at 1:20 P.M. administrative nurse F stated if the resident refused, staff re-approached at least twice and acknowledged the clinical record lacked documentation the resident refused personal cares. He/she acknowledged the resident with body odor. The facility provided October 2010 Shower/Tub Bath policy and procedure documented the facility promoted cleanliness and provided comfort to residents. The policy directed staff to document if the resident refused the shower/tub bath, the reason why, intervention taken, and notify the supervisor if the resident refused. The facility provided January 2007 Assisting Resident with Cleaning Teeth documented if the resident refused to allow his/her teeth to be brushed, try to offer a mouthwash to rinse the mouth. If the resident refused to have his/her teeth brushed, report to the licensed nurse. The facility failed to perform appropriate hygiene to meet the needs of this dependent resident that was unshaved, had food debris on his/her teeth, and had body odor on 3 of 4 days onsite of the survey.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate	F 315		

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treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 171 residents. The sample included 29 residents, with 5 sampled for urinary incontinence. Based on observation, interview and record review, the facility failed to offer toileting to resident #242 and failed to provide perineal care after incontinence for resident #112.

Findings included:

- Resident #242's admission Minimum Data Set (MDS) 3.0 dated 5/25/12 recorded the Brief Interview for Mental Status (BIMS) score was 7 which indicated severe cognitive impairment. The MDS recorded the resident required total staff assistance for locomotion on and off the unit, extensive staff assistance for bed mobility, transfers, dressing, toilet use and personal hygiene. The resident did not walk, had 2 Stage 2 unhealed pressure ulcers, and was at risk of developing more pressure ulcers. The resident did not have a toileting program and was occasionally incontinent of bladder and bowel.

The urinary incontinence Care Area Assessment (CAA) dated 5/29/12 recorded the resident was dependent on 2 staff for hygiene, transfers and toileting needs and wore a brief. The resident had an increased risk of urinary incontinence due to limitations with mobility including non-weight bearing status, pain, depression, blindness, high

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ALDERSGATE VILLAGE	3220 SW ALBRIGHT DR TOPEKA, KS 66614

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blood pressure and osteoporosis (a medical condition in which the bones become brittle and fragile from loss of tissue).

The pressure ulcer Care Area Assessment (CAA) dated 5/29/12 documented the resident had 2 open skin areas on his/her coccyx.

The urinary care plan dated 6/7/12 directed staff to provide assistance for changing the resident's brief, provide perineal care after each incontinent episode, apply moisture barrier cream as needed and provide the resident with assistance for bedpan or toilet use.

The direct care staff 24-Hour Shift Report updated 8/3/12 recorded the resident was occasionally incontinent of bowel and bladder and wore incontinence briefs.

The Bowel and Bladder Assessment dated 5/19/12 recorded the resident had a score of 15 which indicated a potential for habit, prompted or scheduled toileting.

Observation on 8/6/12 at 1:43 P.M. revealed the resident sat in his/her high back wheelchair in his/her room, with his/her legs covered by a blanket. No staff entered the resident's room from 1:43-2:16 P.M.

Observation 8/6/12 at 2:16 P.M. revealed direct care staff W and direct care staff X entered the resident's room and asked the resident if he/she wanted to use the toilet before they assisted him/her to bed. The resident declined.

Observation on 8/6/12 at 2:58 P.M., 3:08 P.M.,

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3:12 P.M., 3:23 P.M., 3:39 P.M. 3:49 P.M., 4:06 P.M., 4:19 P.M., 4:28 P.M., 4:31 P.M. revealed the resident slept in his/her bed. At 4:31 P.M. direct care staff Y entered the resident's room and asked if the resident wanted to get up for supper, and the resident declined. At 4:45 P.M., direct care staff BB and direct care staff W entered the resident's room and asked the resident if he/she wanted to get up for supper, and the resident accepted. Direct care staff BB checked the resident's brief and stated it was dry. Both direct care staff assisted the resident transfer from his/her bed to the wheelchair. Staff failed to ask the resident if he/she needed to use the toilet, and failed to offer the resident assistance to use the toilet.

During an interview on 8/6/12 at 2:49 P.M., direct care staff W stated staff should ask the resident if he/she needed to use the toilet, he/she required 1 staff assistance to get up and go to the toilet, and staff needed to cue the resident to use the toilet.

During an interview on 8/6/12 at 3:50 P.M., licensed nurse K stated the resident was often incontinent of bladder and bowels, did tell staff he/she had to use the toilet occasionally, and staff should ask the resident about every 2 hours to try to use the toilet.

During and interview on 8/6/12 at 4:56 P.M., direct care staff Y stated staff should offer to take the resident to the toilet approximately every 2 hours, and he/she did not let the staff know when he/she needed to use the toilet. Direct care staff Y stated he/she did not know when staff toileted the resident the last time.

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During an interview on 8/6/12 at 5:03 P.M., licensed staff J stated the resident was always incontinent of bladder and bowels, and he/she expected staff to check and change the resident's brief and offer toileting every 2 hours.

During an interview on 8/7/12 at 8:07 A.M., direct care staff CC stated the resident was incontinent of bladder and bowels, would tell the staff if he/she had to go at times, staff toileted the resident every 2 hours, and staff should toilet the resident before and after meals.

During an interview on 8/7/12 at 3:01 P.M., administrative nursing staff E stated staff should have offered toileting to the resident when they got him/her up for supper because he/she was not offered toileting for about 3 hours.

The facility provided the policy entitled Continence Care Management Program dated 1/3/07 which directed, Habit Training was a protocol for residents who did not have a regular voiding pattern and did not have the cognitive ability to delay voiding. Prompted Toileting was a protocol that directed nursing team members to ask the resident if they need to void. When the resident said yes, the resident was assisted to a toilet. When they said no, the resident was asked again within the next hour.

The facility failed to offer toileting to this resident as planned.

- Resident #112's quarterly Minimum Data Set (MDS) 3.0 dated 7/17/12 recorded the resident was severely cognitively impaired. The MDS recorded the resident required total staff

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assistance for personal hygiene, extensive staff assistance for bed mobility, transfers, dressing, eating and toilet use, and limited staff assistance for walking in the room and corridor, and locomotion on and off the unit. The resident was always incontinent of bladder and bowel, and did not have a toileting program.

The urinary incontinence Care Area Assessment (CAA) dated 12/14/11 recorded the resident had advancing Alzheimer's Disease (dementia), vascular dementia, severe cognitive loss and was unable to recognize the need to void resulting in total incontinence of both bowel and bladder, and was on a check and change program approximately every 2 hours and as needed. The resident required extensive to total staff assistance to manage his/her incontinence.

The skin care plan dated 2/5/10 and updated 7/20/12 directed staff to provide perineal care for skin, provide perineal care after each incontinent episode, use an incontinence brief at all times for protection and dignity, and on 2/26/12 check and change the resident's incontinence brief every 2 hours and as needed.

Observation on 8/6/12 at 9:42 A.M. revealed direct care staff Z and direct care staff AA assisted the resident to the bathroom and placed the resident on the toilet. Direct care staff AA removed the resident's soiled incontinence brief and verified the brief was wet with urine. After the resident finished, staff assisted him/her to stand, and staff cleaned the resident by swiping up the center of the gluteus 2 times. Staff failed to completely clean the resident's perineal area.

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F 315	Continued From page 18 Observation on 8/7/12 at 11:52 A.M. revealed direct care staff W and direct care staff Y assisted the resident to the toilet. Direct care staff W verified the resident's incontinence brief was wet with urine and also a small amount of bowel movement. After the resident finished, staff assisted him/her to stand and cleaned the center of the gluteus 12 times. Staff failed to completely clean the resident's perineal area. During an interview on 8/7/12 at 1:54 P.M., direct care staff Y stated the correct way to provide perineal care to a resident with a wet incontinence brief was to clean the resident from the front to the back. During an interview on 8/7/12 at 2:06 P.M., licensed nurse Q stated he/she expected staff to clean all the resident's skin that was in contact with the incontinence brief to make sure to clean off all the urine. During an interview on 8/7/12 at 2:56 P.M., administrative nursing staff E stated he/she expected staff to clean the entire area that the incontinence brief touched to make sure the urine was off the resident's skin. The facility provided the policy entitled Perineal Care dated 11/29/10 which directed staff to clean the perineal area. The facility failed to completely clean the resident after an incontinence episode.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a	F 318		

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resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 171 residents. The sample included 29 residents. Based on observation, record review, and staff interview, the facility failed to provide restorative services for 1 (#194) resident of the 3 residents sampled for restorative.

Findings included:

- The admission minimum data set (MDS) dated 5/11/12 for resident #194 revealed the resident had severely impaired cognitive skills for decision making; the resident required extensive assist with two plus persons physical assist with bed mobility, transfers, dressing, toilet use, and personal hygiene; extensive assist of one person physical assist with locomotion on the unit and eating; total dependence of one person physical assist with locomotion off the unit; the resident did not have limitation in range of motion (ROM) to the upper or lower extremities; a wheelchair was used for mobility; and the resident received 303 minutes of occupational therapy (OT) and 269 minutes of physical therapy (PT) in the last seven days.

The care plan dated 5/14/12 for activities of daily living (ADLs) revealed the resident used a Broda

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chair and was unable to propel his/her own self; staff provided extensive to total assist for all activities of daily living (ADLs), repositioning, and transfers; and staff used lower extremity positioning device when the resident was supine.

The OT discharge note dated 5/22/12 revealed the OT staff recommended a restorative aide program for passive ROM (PROM), feeding, and grooming.

The 5/24/12 restorative care program form revealed the goals for bilateral upper extremity ROM were to maintain hands for feeding and grooming.

The PT discharge note dated 6/4/12 revealed PT recommended a restorative program to maintain ROM of the bilateral lower extremities; and use a lower extremity positioning device to prevent further contracture of the lower extremity.

The record lacked documentation of restorative services received to the lower extremities.

The restorative nursing assessment dated 7/20/12 revealed the resident had right and left hip/knee contracture; the resident had functional limitation in the ROM to the leg which included the hip and knee, and indicated limitation and full loss of both sides; the resident had minimal loss of dorsiflexion of both ankles and extension of both hips; and moderate to severe partial loss of extension of both knees.

Observation on 8/2/12 at 12:59 P.M. revealed the resident sat in the dining room in a Broda chair wearing foam boots on each foot.

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F 318	Continued From page 21 Observation on 8/6/12 at 4:30 P.M. revealed the resident laid in bed sleeping. Staff interview on 8/7/12 at 7:30 A.M. with licensed nursing staff R stated staff followed restorative cares with the resident; and she/he did not have restorative care records for ROM for the lower extremities. Staff interview on 8/7/12 at 9:30 A.M. with licensed nursing staff R stated the resident's record lacked documentation the resident received ROM to the lower extremities; the restorative aide provided restorative services to the upper extremities; and staff did not follow-up with the PT orders. The policy and procedure for restorative nursing, dated 4/2/09, revealed restorative programs were set up with the purpose of helping the resident progress to a higher level of function or restore function. Restorative nursing programs supplement and reinforce the gains made in therapy, to help the resident progress to her/his optimal level of independence. The facility failed to provide restorative services to the lower extremities of this dependent resident as planned.	F 318		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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This REQUIREMENT is not met as evidenced by:
The facility identified a census of 171 residents. The sample included 29 residents. Based on observation, interview and record review the facility failed to utilize fall interventions as planned for 1 (#160) of 4 residents sampled for falls resulting in a fracture of the hip and failed to ensure a safe bathing environment in 4 of 6 showers for 2 of 4 days onsite of the survey.

Findings included:

- Resident #160's Quarterly Minimum Data Set (MDS) 3.0 dated 5/24/12 documented the resident with a Brief Interview for Mental Status Score of 0, which indicated the resident with severe cognitive impairment. He/She required extensive assistance with bed mobility, transfers and toileting. The resident had no falls in the last month, or the last 2-6 months and no fractures related to falls in the last 6 months prior to admission.

The Care Area Assessment (CAA) for falls dated 12/14/11 recorded the resident fell in October resulting in an overnight hospital admission with a concussion and clavicular fracture from which he/she had fully recovered. He/She was on the falling star program and had a new lower highback chair that could be move about easier as well as bed and chair pad alarms.

The care plan for falls initiated 6/09/10 and last

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reviewed 7/21/12 directed the staff to have the resident sit in an arm chair during meals or broda chair, do quarterly fall assessments and as warranted. On 7/22/11 staff added the resident to the falling star program. Staff were to anticipate and meet the resident's needs and ensure the resident had a bed alarm and chair alarm. Staff were to check the alarms for proper placement and functioning every shift.

The Fall Risk Evaluation dated 5/18/12 indicated the resident at risk for falls.

Progress Note dated 7/21/12 at 10:59 P.M. documented staff heard the resident yelling. Staff observed the resident who laid on his/her back on the floor behind the resident's broda chair at about 3:15 P.M. The resident was assessed on the floor and no obvious injuries were found. Two direct care staff and the nurse assisted the resident to a chair then got the lift and put the resident back in the broda chair. The resident complained of left hip pain when staff rotated his/her leg from side to side. The resident rated his/her pain at an 8 on a scale of 1-10 with 10 as the worst pain. Staff notified the physician and family and the resident was transported to the hospital by ambulance. The resident admitted to the hospital with a broken left hip.

The clinical record contained an X-ray dated 7/21/12 which recorded findings compatible with a mildly displaced right femoral neck fracture with the appearance of a linear fracture fragment which appeared to include a portion of a lesser trochanter. The osseous structures were normally mineralized.

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A Consultation Report dated 7/21/12 from the physician recorded the resident fell off a chair and that caused a fracture.

Further review of the clinical record revealed the resident returned to the facility on 7/25/12 from the hospital and later passed away.

Review of the facility fall investigation dated 7/21/12 documented the resident fell at 3:10 P.M. in the day room and licensed nursing staff M heard the resident and ran to the resident. The resident laid on the floor beside the broda chair. The resident had been folding clothing prior to the fall. Staff sent the resident to the hospital where the resident underwent surgery to repair a hip fracture. The facility investigation showed prior to the fall, the night shift nurse reported the resident's pad alarm did not function and the nurse attempted to repair the alarm, but failed. Staff placed the box portion of the wireless pad alarm that did not function at the nurse's station and left the pad under the resident. Staff reported they did not have a functioning alarm under the resident since the resident laid in bed. Staff reported toileting the resident at 1:30 P.M. and the alarm did not function at that time. The day shift nurse documented the alarm was checked, but during an interview with facility staff he/she admitted the staff did not check the resident's alarm for placement and function.

During interview on 8/6/12 at 4:51 P.M. licensed nursing staff S reported he/she made rounds often and checked on residents to make sure they are safe and have the appropriate interventions in place and to ensure staff are following the resident's care plan.

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F 323	Continued From page 25 During interview on 8/7/12 at 10:01 A.M. licensed nursing staff P reported the facility's fall precautions included having the resident use a low bed, keeping the call light in reach, prompt answering of resident's call lights, frequent observation and providing activity of daily living assistance. During interview on 8/7/12 at 4:47 P.M. licensed nursing staff L reported licensed nurse U, the nurse on duty at the time of the fall, falsified records when he/she charted the resident's alarm was checked for functioning and placement. When the resident fell out of the Broda chair staff did not have a functioning alarm under the resident to alert staff that the resident tried to get up out of the chair. The resident had a history of attempting to repeatedly stand up from the chair alone without assistance, had a history of falls and the alarm would alert staff to the resident's attempt to stand, thus could redirect the resident or assist the resident and prevent him/her from falling. The fall happened at shift change and the nurse going off shift failed to ensure the resident had a functioning alarm to assist with the resident's safety and the oncoming nurse failed to check the resident to ensure the resident's alarm was in place and functioning. Staff L reported the facility was responsible for this resident's fall and staff should check at the beginning of the shift to ensure resident fall interventions were in place and that fall alarms were in place and functioning. He/She acknowledged the facility failed to keep the resident safe and some facility licensed staff were terminated from their positions. The facility provided a notarized statement written	F 323		

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by licensed nurse L who wrote on 7/23/12 he/she interviewed licensed nurse U regarding the incident of 7/21/12 who reported he/she checked the bed alarm, but did not check the chair alarm. Upon reviewing the information, licensed nurse L stated licensed nurse U signed off documenting he/she checked the chair alarm, when he/she had not.

The facility provided a policy entitled Personal Alarms revised 6/13/12 which directed it was the responsibility of all staff on each shift caring for a resident with a personal alarm to perform testing of the alarm. Each individual should immediately report any alarm that is not functioning correctly to the charge nurse. Malfunctioning alarms would be replaced immediately if the replacement of the battery does not resolve the problem.

The facility failed to utilize fall interventions as planned for this resident with a history of falls which resulted in a fall with injury.

Observation during an environmental tour on 8/7/12 from 9:00 A.M. to 11:00 A.M. revealed the shower rooms on Lincoln, Eastminster, Westminster, Mulvane Square, and Norwich Plaza lacked non-skid surfaces.

Staff interview on 8/7/12 at 9:30 A.M. with environmental staff LL stated shower rooms on all the units should have bath mats in the shower/bath areas.

Staff interview on 8/7/12 at 10:10 A.M. with nursing staff L stated nursing staff used bath/shower mats when giving a resident a

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F 323	Continued From page 27 bath/shower when a resident needed to stand during the shower; and the shower mat was not needed if the resident sat in a shower chair. Staff interview on 8/7/12 at 3:00 P.M. with administrative staff A and administrative nursing staff D stated staff used shower mats in the bath/shower rooms per facility policy. The undated Policy and Procedure for shower/tub bath revealed staff placed a non-skid bath mat on the floor where the resident would step in/out of the tub or shower. The facility failed to provide non-skid surfaces in 5 of the 7 unit shower/bathing rooms.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 329		

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F 329	Continued From page 28 contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: The facility reported a census of 171 residents. The sample included 29 residents. Based on observation, record review, and interview, the facility failed to monitor behavioral medications for 1(#181) of the 10 residents sampled for unnecessary medications. Finding included: - The Physician's Order Sheet (POS) dated 6/11/11 for resident #181 revealed diagnoses of mood disorder, anxiety, and depressive disorder. The quarterly Minimum Data Set (MDS) dated 5/16/12 revealed the resident had long/short term memory problems, was unable to recall the current season, location of own room, staff names/faces, and that she/he was in a nursing home; the resident had severely impaired cognitive skills for daily decision making; required total dependence of two plus persons physically assisting with bathing; and received antipsychotic, anti-anxiety, and antidepressant medications. The revised care plan dated 5/24/12 for psychotropic medication use revealed the resident received an antipsychotic for agitation associated with dementia and as needed (PRN) for increased agitation; staff monitored the	F 329		

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effectiveness and side effects of the psychogenic medication on an ongoing basis; staff reported to the physician as needed; and staff completed a quarterly Abnormal Movement Scale (AIMS) test.

The POS dated 6/11/12 revealed orders for Ativan (an Benzodiazepine)1 milligram (mg) by mouth (PO) PRN for agitation and anxiety; Ativan (an Benzodiazepine) 1 mg PO PRN 30 minutes before a shower for agitation with cares: Haldol (an antipsychotic) 1 mg PO PRN 30 minutes before a shower for agitation with cares; Seroquel (an antipsychotic) 25 mg PO three times daily (TID) for agitation; and Trazadone 50 mg PO four times daily (QID) for depression.

The Medication Regimen Review (MRR) dated 7/23/12 revealed the pharmacy consultant recommended nursing staff to provide behavior monitoring for behavioral medications.

Observation on 8/6/12 at 10:10 A.M. revealed the resident slept in a Broda chair in the dining room with 5 other residents who watched television.

Observation on 8/6/12 at 3:01 P.M. revealed the resident slept in bed with the call bell within reach.

Staff interview on 8/6/12 at 4:13 P.M. with direct care staff II stated certified nursing aides (CNAs) provided the resident's bath and the resident received medication to help calm her/him down 30 minutes before her/his bath; the resident would yell out and hit at staff when she/he received a bath and demonstrated this behavior frequently; and the medication did not always help in calming the resident down.

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F 329	Continued From page 30 Staff interview on 8/6/12 at 4:23 P.M. licensed nursing staff T stated the resident received Ativan and Haldol on shower days for agitation and combativeness with showers and if the resident was not demonstrating behaviors she/he held the medications; and nursing staff used behavioral monitoring sheets to monitor effectiveness of the behavioral medications used. Staff interview on 8/7/12 at 8:35 A.M. with direct care staff JJ stated nursing staff documented the resident's behavioral medications on the behavioral monitoring form. Staff interview on 8/7/12 at 1:16 P.M. with licensed nursing staff N stated the resident had outbursts and the Seroquel helped with the outburst; the resident would holler out when nursing staff provided cares; nursing staff initiated the behavioral monitoring forms with new antipsychotic medication orders; and the unit manager replaced the behavioral monitoring forms each month. Record review lacked documentation of a Behavioral Monitoring form for Seroquel and/or Haldol for May, June, July, and August 2012. The undated and May 2012 Behavioral Monitoring form revealed staff monitored the resident for the medications Ativan (Benzodiazepine) 0.5 mg. The clinical records lacked documentation for a June 2012 behavioral monitoring form. The July 2012 Behavior Monitoring form revealed	F 329		

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staff monitored the resident for the medications Ativan (Benzodiazepine) 0.5 mg and Trazadone (antidepressant) 50 mg.

The August 2012 Behavior Monitoring form revealed staff monitored the resident for the medications Ativan 1 mg (Benzodiazepine), Haldol 1 mg (antipsychotic) and added Seroquel 25 mg on 8/7/12 to the behavioral form.

Staff interview on 87/12 at 1:41 P.M. with administrative nursing staff F stated nursing staff should have initiated a behavioral sheet for antipsychotic medications the resident received; and nursing staff documented resident behaviors by exception.

Staff interview on 8/7/12 at 2:01 P.M. with pharmacy consultant NN stated the MRR for 7/23/12 asked nursing staff to provide behavioral monitoring forms for the antipsychotic medications as the consultants were unable to find them; and found only an undated behavioral monitoring form in the resident's chart.

Staff interview on 8/7/12 at 3:00 P.M. with administrative nursing staff D stated staff used the behavior monitoring forms to monitor antipsychotic and anti-anxiety medications; and nursing staff initiated the behavioral monitoring forms when a antipsychotic/anti-anxiety medication was started; and the pharmacy recommendation were reviewed by the director of nursing (DON), and provided to the unit managers to follow up.

The undated policy and procedure for medication monitoring - psychoactive drugs revealed

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F 329	Continued From page 32 residents who received antidepressant, hypnotic, antianxiety, or antipsychotic medications were monitored to evaluate the effectiveness of the medication. Behavioral monitoring charts or similar mechanism were used to document the resident's need for and response to drug therapy. The facility failed to monitor the effectiveness of Seroquel and Haldol for this dependent resident.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: The facility reported a census of 171 residents. Based on observation, interview and review of cleaning schedules, the facility failed to maintain a clean and sanitary food preparation area of the main kitchen, failed to assure foods were labeled and stored under sanitary conditions and failed to maintain hair restraints in the main kitchen food service area and 1 of 7 kitchenettes. Findings included: - During the initial tour of the main kitchen on 8/01/12 from 9:38 A.M.- 10:03 A.M., observations	F 371		

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F 371	Continued From page 33 revealed: Kitchen staff RR and SS in the food preparation area of the kitchen. Staff RR worked in the kitchen area mixing food in a large bowl wearing a black cap with hair exposed on the sides and back of his/her head. Staff SS stood in the kitchen and he/she reached into the refrigerator and removed several foods labeling them and returned them to the refrigerator. He/She had facial hair uncovered and exposed. Stainless Steel shelf with buildup of dust and debris. Pans stored by the mixer on the bottom shelf of the metal rack were stored upright. Pot/pan storage near the back wall on a wire rack with pans stored upright and uncovered. Plates on rack near back of kitchen stored upright. The walk - in refrigerator contained a box with an open lid of undated eggs. The block wall behind the stove had dried splatter on it and food debris along it on the floor. During interview, on 8/01/12 from 9:38 A.M.-10:03 A.M., Dietary Staff SS reported the kitchen did have a cleaning schedule and acknowledged the dirty kitchen surfaces were due to be cleaned. They reported staff would need to dispose of the undated, open container of eggs. He/She acknowledged the staff should store pans and plates inverted. Dietary staff SS reported his/her facial hair was not covered because he/she did not work around food and he/she instructed dietary staff RR to wear a hair net under the black cap to contain all of his/her hair while in the kitchen. - Dining observation on 8/01/12 at 12:04 P.M. -	F 371		

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F 371	Continued From page 34 1:23 P.M., in the Mulvane dining room revealed kitchen staff with hair uncovered working with food. Observation in the dining room revealed at 1:02 P.M. staff fed a resident, shook another resident's hand and staff did not wash or sanitize his/her hand. - Observation on 8/02/12 at 9:00 A.M. revealed four dietary staff working in the kitchen with hair exposed, three of those staff immediately exited the kitchen area and donned hair nets over their facial hair, then returned to the kitchen. - Observation on 8/06/12 at 10:22 A.M. revealed a large trash receptacle filled with trash that spilled up over the top with the lid unsecured and trash spilled out onto the floor located behind the kitchen preparation area. During interview on 8/06/12 at 10:22 A.M. dietary staff TT reported staff take the trash out several times a day and the trash needed to be taken out, but that task was assigned to the dish washer staff who was on break. The facility did not provide a policy for the food preparation. The facility failed to store, prepare, distribute and serve food under sanitary conditions.	F 371		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency	F 412		

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dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 171 residents. The sample included 29 residents. Based on observation, interview, and record review the facility failed to provide a dental consultation the physician ordered for 1 of 3 residents reviewed for dental care. (#1)

Findings included:

- Resident #1's annual Minimum Data Set 3.0 Assessment dated 7/4/12 documented the resident with moderately impaired decision making skills. The resident required total assistance of staff for personal hygiene and oral care.

The Cognition Care Area Assessment summary (CAA) dated 7/24/12 documented the resident refused care during the observation period, was alert and oriented to person, place, and time, able to make decision about his/her daily care, and able to communicate his/her needs.

The Dental CAA dated 7/24/12 documented the resident with a number of his/her own natural teeth missing, and remaining teeth broken off or with fillings and required extensive to total assistance from staff for completion of his/her

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F 412	Continued From page 36 daily oral hygiene needs. The 7/24/12 revised care plan identified the resident with a deficit in self care related to his/her impaired mobility and required assistance with oral care daily. Record review revealed a physician's order dated 3/21/12 for a referral for the resident to see a dentist. The clinical record lacked evidence the resident saw a dentist since the 3/21/12 order. Observation on 8/1/12 at 2:29 P.M. revealed the resident had food debris in his/her teeth and some of the teeth missing and some broken. During staff interview on 8/7/12 at 11:14 A.M. licensed nurse NN stated when staff received an order for a dental consultation, he/she forwarded it to social services to make the appropriate referrals based on the resident's financial needs. During staff interview on 8/7/12 at 10:55 A.M. administrative staff B was unaware the physician ordered a dental consultation for the resident and would contact the resident's Durable Power of Attorney for consent to obtain a referral for the resident to see a dentist. He/she acknowledged staff did not make him/her aware of the order. The facility failed to follow the physician's order to obtain a dental consultation for this dependent resident with poor dental health.	F 412		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	Continued From page 37 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: The facility identified a census of 171 residents. Based on observation and interview, the facility	F 431		

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F 431	Continued From page 38 failed to label open multi-use insulin vials with an open date in 1 of 6 medication rooms. Findings included: - Observation on 8/1/12 at 9:24 A.M. of the Eastminster medication room revealed 2 open, undated insulin vials labeled with 2 current resident names. During an interview on 8/1/12 at 9:24 A.M., licensed nurse J stated the staff should date the insulin vials when opened and the insulin was good for 28 days after opening. During an interview on 8/1/12 at 9:44 A.M., administrative nursing staff E stated staff should marked the insulin vials with the open date and discard and reorder the insulin after 28 days. The facility provided the policy entitled Insulin Expiration (28 days) dated 8/4/03 directed the nurse who opened a new insulin vial to date the vial with that day's date, and would be used for the remaining 28 calendar days. The facility failed to label the opened insulin vials with an open date.	F 431		